PEDIATRICS IN BREVARD
MEDICAL RECORDS RELEASE AUTHORIZATION

Please Print Clearly

Patient's Full Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Please Check One:
Sending Records To:__ Obtaining Records From:__

Physician/Facility
Complete Name:_____
Please Check One: Primary Care Physician_____ or Specialist_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

Information to be sent or received: (check all that apply)
Entire Record _____
Immunizations _____
X-Ray Reports _____
Laboratory Reports _____
Other _____ Specify:_____

The patient or patient's representative must read and initial the following statements:

I understand the health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.
Initial_____

I understand that this authorization will expire on _____.
If a date is not specified, this authorization will expire in 12 months.
Initial_____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do it in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
Initial_____

Pediatrics In Brevard will not condition your treatment on you completing and signing this authorization.
Initial_____

Signature of
Patient or Patient's Representative:_____ Date:_____
Relationship to Patient:_____

134 S. Woods Dr., Rockledge, FL 32955	(321) 636-3066	Fax (321) 636-2545
1755 W. Hibiscus Blvd., Melbourne, FL 32901	(321) 724-5437	Fax (321) 724-5570
699 W. Cocoa Beach Cswy. Ste. 401, Cocoa Beach, FL 32931	(321) 784-5437	Fax (321) 799-1231
7332 Office Park Place Ste. 103, Viera, FL 32940	(321) 435-9800	Fax (321) 435-9803